U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 28 September 2006

Case No.: 2003-BLA-6477

In the Matter of:

C.L.H., Widow of E.T.H.,
Claimant

v.

ARCH ON THE GREEN, INC.,
Employer

LIBERTY MUTUAL INSURANCE COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Sandra M. Fogel, Esq.
For the Claimant

Francesca Maggard, Esq.
For the Employer

BEFORE: Joseph E. Kane
Administrative Law Judge

DECISION AND ORDER – GRANTING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901, *et seq.* (the "Act"). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001).

C.H. ("Claimant"), represented by counsel, appeared at the formal hearing held April 18, 2006, in Madisonville, Kentucky. I afforded both parties the opportunity to offer testimony, question witnesses, and introduce evidence. Thereafter, I closed the record. I based the following Findings of Fact and Conclusions of Law upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. Although perhaps not specifically mentioned in this Decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. Although the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformity with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this Decision exclusively pertain to that Title. References to DX, CX, and EX refer to the exhibits of the Director, Claimant, and Employer, respectively.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Procedural History

E.T.H. ("Miner") married Claimant on September 29, 1962. (DX 9). The couple was married until the Miner's death on June 8, 2001. (DX 10). Claimant filed the current claim for survivor's benefits on September 4, 2002. (DX 2). In a Proposed Decision and Order, the District Director awarded Claimant benefits on May 8, 2003. (DX 30). Employer requested a formal hearing and the claim was transferred to the Office of Administrative Law Judges on August 12, 2003. (DX 31, 35).

Claimant testified to the Miner's breathing condition. She stated that the Miner suffered from cough and shortness of breath. His breathing condition continued to deteriorate until his death. (Tr. 27). The Miner was unable to fish, garden, or even mow the lawn due to his breathing condition. (Tr. 27). He used an inhaler and a nebulizer three times a day. (Tr. 29). However, the breathing machine only provided him with temporary relief. (Tr. 30). The Miner smoked one to one-and-a-half packs of cigarettes per day between 1957 and 1996. (DX 5). Claimant stated that the Miner went through a carton of cigarettes every two weeks. (Tr. 33).

Contested Issues

The parties contest the following issue regarding this claim:

1. The length of the Miner's coal mine employment;

2. Whether the Miner had pneumoconiosis as defined by the Act and the regulations;

3. Whether the Miner's pneumoconiosis, if present, arose out of coal mine employment; and,

4. Whether the Miner died due to pneumoconiosis.

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. The District Director made a finding of 10 years of coal mine employment. (DX 30). The Employer would only stipulate to eight years of coal mine employment at the hearing. The documentary evidence includes the Miner's Social Security earnings report and employment questionnaire. The Social Security earnings report reflects the following coal mine employment earnings history:[1]

Year	Earnings	Industry Average for 125 days of CME	Years of Coal Mine Employment
1957	$ 131.88	$ 2,172.50	0.06
1958	927.72	$ 2,130.00	0.44
1959	1,435.06	$ 2,183.75	0.66
1960	782.72	$ 2,266.25	0.35
1961	0.00	$ 2,645.00	0.00
1962	0.00	$ 2,717.50	0.00
1963	0.00	$ 2,835.00	0.00
1964	0.00	$ 3,031.25	0.00
1965	0.00	$ 3,222.50	0.00
1966	0.00	$ 3,438.75	0.00
1967	0.00	$ 3,662.50	0.00
1968	0.00	$ 3,801.25	0.00
1969	0.00	$ 4,261.25	0.00
1970	0.00	$ 4,777.50	0.00
1971	0.00	$ 5,008.75	0.00
1972	0.00	$ 5,576.25	0.00
1973	0.00	$ 5,898.75	0.00
1974	7,914.53	$ 6,080.00	1.00
1975	14,100.00	$ 7,405.00	1.00
1976	15,300.00	$ 8,008.75	1.00
1977	12,738.86	$ 8,987.50	1.00
1978	13,558.62	$10,038.75	1.00
1979	6,488.96	$10,878.75	0.60
1980	22,386.59	$10,927.50	1.00
1981	20,463.03	$12,100.00	1.00
1982	28,451.45	$12,698.75	1.00
1983	3,557.11	$13,720.00	0.26
		Total	10.37 years

[1] The regulatory provisions at 20 C.F.R. § 725.101(a)(32)(2001) make reference to a table developed by the *Bureau of Labor Statistics*. However, this table does not exist. Rather, the Department uses a table, which is identified as Exhibit 610 of the *Office of Workers' Compensation Programs Coal Mine (BLBA) Procedural Manual*. This table is updated periodically by OWCP. I have used this table above.

Accordingly, based upon all the evidence in the record, I find that the Miner was a coal miner, as that term is defined by the Act and regulations, for 10.37 years. He last worked in the Nation's coal mines in 1983. (DX 3, 7).

Medical Evidence

Medical evidence submitted with a claim for benefits under the Act is subject to the requirement that it must be in "substantial compliance" with the applicable regulations' criteria for the development of medical evidence. *See* 20 C.F.R. §§ 718.101 to 718.107. The regulations address the criteria for chest x-rays, pulmonary function tests, physician reports, arterial blood gas studies, autopsies, biopsies, and "other medical evidence." *Id.* "Substantial compliance" with the applicable regulations entitles medical evidence to have probative weight as valid evidence.

Secondly, medical evidence must comply with the limitations placed upon the development of medical evidence. 20 C.F.R. § 725.414. The regulations provide that a party is limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. §§ 725.414(a)(2)(i), 725.414(a)(3)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports, and physician opinions that appear in one single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test or arterial blood gas study. §§ 725.414(a)(2)(ii), 725.414(a)(3)(ii). Likewise, the District Director is subject to identical limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i-iii).

A. X-ray Reports[2]

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
DX 14	11/05/00	Wheeler B/BCR	No abnormalities consistent with pneumoconiosis
CX 1	11/05/00	Cappiello B/BCR	1/0
CX 2	11/05/00	Ahmed B/BCR	1/0
EX 8	11/05/00	Scott[3]	
CX 3	12/03/00	Ahmed B/BCR	1/1

[2] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(a) and (b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease.

[3] On Employer's evidence summary form it designates a reading by Dr. Scott as rebuttal evidence. However, this reading is not located within the record and, therefore, I cannot take it into consideration.

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
EX 7	12/03/00	Wheeler B/BCR[4]	
DX 14	1/04/01	Wheeler B/BCR	No abnormalities consistent with pneumoconiosis.

B. Death Certificate

The Miner died June 8, 2001. (DX 10). Barry Hardison, M.D., was the physician who signed the Death Certificate. He was the Miner's treating physician. (Tr. 28). Dr. Hardison noted that the Miner's death was caused by chronic lung disease. (DX 10).

C. Autopsy Reports

Mark M. LeVaughn, M.D., Board-certified in Pathology, performed an autopsy on June 8, 2001. (DX 12). Dr. LeVaughn diagnosed the Miner with acute bronchopneumonia based on his findings of acute inflammatory exudate in the proximal and distal airways. He also found chronic lung disease, emphysema, and chronic bronchitis. Dr. LeVaughn found no evidence of pericardial or pleural adhesions; however, he noted scattered black pigment throughout the lungs. Upon conducting the microscopic examination he noted a finding of moderate to severe emphysema with scattered subpleural and periarteriolar black pigment deposition. He noted changes of moderate to severe chronic bronchitis and interstitial fibrosis containing black pigment. Dr. LeVaughn opined that the Miner died as a result of acute bronchopneumonia. Severe chronic lung disease and atherosclerotic cardiovascular disease were noted as secondary causes. (DX 12).

D. Narrative Medical Reports

Dr. LeVaughn also provided a narrative medical report. (CX 4). To prepare his report he reviewed the autopsy slides. Dr. LeVaughn noted that he found mild to moderate submucosal chronic inflammation, patchy interstitial fibrosis, and acute bronchopneumonia. He also found "mild to moderate centrilobular emphysema with mild periarterilar and peribronchiolar interstitial scarring containing small amounts of black pigment." Dr. LeVaughn stated that the examination revealed subpleural black pigment. He found no evidence of progressive massive fibrosis. However, based on these findings Dr. LeVaughn opined that the Miner suffered from pneumoconiosis.

William C. Houser, M.D., Board-certified in Pulmonary Diseases and Critical Care Medicine, provided a consultative report on March 28, 2006. (CX 5). Dr. Houser examined all the medical evidence in the record. He then summarized all the treatment reports, the autopsy, and the reports of the other physicians of record. Dr. Houser opined that the Miner's "emphysema, chronic bronchitis, and associated obstructive airway disease [was] at least in part

[4] Dr. Wheeler's December 3, 2000, chest x-ray reading is also not located in the record and cannot be taken into consideration. Furthermore, the record includes Dr. Wheeler's deposition testimony located at EX 5. However, 20 C.F.R. § 725.457 only permits deposing a doctor who has submitted a medical report. A party can choose to use a deposition instead of a medical report, but in this case Employer has already designated the medical reports of Drs. Jarboe and Fino. Therefore, Dr. Wheeler's deposition cannot be taken into consideration.

secondary to the inhalation of coal and rock dust as a result of his coal mine employment." Based on his medical research he believed that the Miner's respiratory conditions and pneumoconiosis caused the Miner to suffer from hypoxemia which lead to polyoythemia and pulmonary hypertension. Dr. Houser based his pneumoconiosis and emphysema findings upon the Miner's history of exposure, chest x-rays, and the pathology evidence. He attributed these conditions to the Miner's death. Dr. Houser stated that "individuals who have coal workers' pneumoconiosis and/or chronic obstructive pulmonary disease (chronic bronchitis and/or emphysema (have an increased morbidity and mortality associated with acute respiratory events such as acute bronchitis and pneumonia." He also noted that the Miner had previously suffered from respiratory failure. (CX 5).

Gregory J. Fino, M.D., Board-certified in Internal Medicine with a Subspecialty in Pulmonary Diseases, provided a consultative report on October 28, 2002. (DX 13). Dr. Fino examined the Miner's treatment records, the Death Certificate and the autopsy report. He noted that the Miner suffered from emphysema and chronic bronchitis based on the findings on the autopsy. He opined that the conditions were unrelated to coal dust exposure based on the microscopic description of the lungs. However, Dr. Fino was unable to comment on the Miner's actual cause of death. He suspected that the death was related to smoking but he was unsure. (DX 13).

Dr. Fino also submitted a supplemental report dated November 24, 2003. (EX 4). Dr. Fino reviewed the rest of the medical evidence in the record to formulate an opinion. He summarized the evidence that he reviewed. He noted that the Miner smoked one to one-and-a-half packs of cigarettes per day for a total of 39 years. Dr. Fino discussed that either coal dust exposure or smoking caused the Miner's respiratory condition. However, he determined that "the pattern of abnormality in the clinical course as described during the hospitalizations was consistent with cigarette smoking." Dr. Fino opined that the condition was unrelated to coal dust exposure. He stated that there was insufficient evidence to make a diagnosis of pneumoconiosis. However, in his supplemental opinion Dr. Fino failed to state an opinion on the Miner's cause of death. He only discussed that the Miner had a disabling respiratory condition related to smoking. (EX 4).

Thomas M. Jarboe, M.D., Board-certified in Internal Medicine and Pulmonary Diseases, supplied a consultative report on July 8, 2003. (EX 1). Dr. Jarboe reviewed and summarized the Miner's medical records within the record. First, he found no evidence of clinical pneumoconiosis based on the chest x-ray findings of Drs. O'Bryan and Wheeler. He did not review the actual films himself. Dr. Jarboe also opined that the Miner suffered from severe pulmonary emphysema related to a 65 pack year smoking history. He determined that the condition was unrelated to coal dust exposure based on his finding of "no radiographic, physiological or anatomical evidence that [the Miner] had the disease of coal worker's pneumoconiosis or any other occupationally acquired pulmonary condition." Dr. Jarboe noted that the Miner suffered from a severe totally disabling respiratory impairment related to smoking-induced emphysema prior to his death. He further opined that the Miner's death was no way related to coal dust exposure. Based on the autopsy, Dr. Jarboe stated that the Miner died as a result of acute bronchopneumonia and severe chronic lung disease. He stated that "the

prosector makes no mention of coal worker's pneumoconiosis as a contributing factor in his death." (EX 1).

Dr. Jarboe reiterated his findings in his deposition testimony taken October 21, 2003. (EX 3). Dr. Jarboe stated that he believed that when Dr. LeVaughn performed the autopsy he was looking for pneumoconiosis. As a result, when Dr. LeVaughn made no diagnosis of pneumoconiosis, Dr. Jarboe assumed there was no pneumoconiosis in the Miner's lungs. Dr. Jarboe opined that the Miner died as a result of bronchopneumonia. He stated that this is common in patients suffering from advanced lung and heart disease. Dr. Jarboe also discussed that chronic obstructive pulmonary disease and emphysema were contributing factors to the Miner's death. Dr. Jarboe explained that he based his opinion on the Miner's smoking history, autopsy findings, no evidence of a restrictive disease, and the fact that although the Miner suffered from emphysema, he had no coal dust macules in his lungs. However, Dr. Jarboe agreed that he never reviewed the chest x-ray films or the autopsy slides himself. (EX 3).

G. Hospital and Treatment Records

The amended regulations provide that, notwithstanding the evidentiary limitations contained at 20 C.F.R. § 725.414(a)(2) and (a)(3), "any record of a miner's hospitalization for respiratory or pulmonary or related disease may be received into evidence." 20 C.F.R. § 725.414(a)(4). Furthermore, a party may submit other medical evidence reported by a physician and not specifically addressed under the regulations under § 718.107, such as a CT scan.

First, Claimant submitted hospital and treatment records from Muhlenberg Community Hospital. (CX 6). Throughout the records the physicians diagnosed the Miner with severe end-stage chronic obstructive pulmonary disease, congestive heart failure, pulmonary hypertension, respiratory failure, cerebrovascular disease, pneumonia, acute chronic bronchitis, emphysematous lung disease and possible lung cancer. The Miner's symptoms included chest pain, cough, and severe shortness of breath. The lung examinations revealed scattered wheezing, rhonchi, and decreased breath sounds. The physicians never related any of the above conditions to coal dust exposure. There is only one notation stating a diagnosis of pneumoconiosis. (CX 6, p. 32). However, Dr. Hardison provided no basis for this finding. (CX 6).

The records also included a CT scan and a number of chest x-ray readings. (CX 6). Dr. Chavda performed a CT scan on April 18, 2001. The CT scan revealed a mass in the Miner's lower lobe that was suspicious for malignancy. Dr. Chavda noted that the mass could be lung cancer or merely just pneumonia and scarring. However, due to the Miner's terminal state, no further testing or work-up could take place. Nine chest x-ray readings were included in the records; however, none of the readings included findings of pneumoconiosis. They all revealed basilar infiltrate, chronic obstructive pulmonary disease, pneumonia, and the mass in the Miner's lower right lobe. The physicians never related the conditions to coal dust exposure. (CX 6).

The Miner also received treatment at Owensboro Mercy Hospital. (CX 7). His symptoms included chest pain, trouble breathing, shortness of breath and some cough. He was diagnosed with chronic obstructive pulmonary disease, congestive heart failure, respiratory

failure, chronic hypoxemia, asthmatic bronchitis, and emphysema. None of the physicians ever related the conditions to coal dust exposure. The records also included 13 chest x-ray readings; however, none of the readings included a finding of pneumoconiosis or any other coal dust-related condition. (CX 7).

John T. Lee, M.D. treated the Miner at Vanderbilt University Medical Center between November 6, 2000, and November 10, 2000. (CX 8). He diagnosed the Miner with spinal myoclonus of abdominal rectus muscles, pericarditis of unknown etiology, chest pain, congestive heart failure, and coronary artery disease. Dr. Lee also made a notation of chronic obstructive pulmonary disease and "miner's lung." However, he provided no basis for these findings. He conducted chest x-rays and CT scans but made no findings of pneumoconiosis. However, Dr. Lee noted possible metastatic cancer. (CX 8).

The Employer submitted the treatment records from William O'Bryan, M.D. (EX 2). He noted that the Miner suffered from severe chronic obstructive pulmonary disease, asthmatic bronchitis, emphysema, acute respiratory failure, and pneumonia. He never stated whether the conditions were related to smoking or coal dust exposure. The Miner's symptoms included shortness of breath, productive cough, wheezing, and smothering. Upon examination the Miner's lungs revealed extremely diminished air entry, expiratory wheezes, and decreased breath sounds. (EX 2).

DISCUSSION AND APPLICABLE LAW

Under the applicable regulations, the claimant must establish by a preponderance of the evidence that the Miner had pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that his death was due to pneumoconiosis. *See, Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85, 1-88 (1993). Failure to establish any of these elements precludes entitlement to benefits. Thus, the Claimant Widow must demonstrate that the Miner had pneumoconiosis, which arose from coal mine employment, and that his death was due to pneumoconiosis in order for benefits to be awarded.

Pneumoconiosis

The Act defines pneumoconiosis as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis.

> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis,

anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease, which may first become detectable only after the cessation of coal mine dust exposure. 20 C.F.R. §718.201.

Section 718.202 provides four means to establish pneumoconiosis: by chest x-ray, a biopsy or autopsy, by presumption under §§ 718.304, 718.305, or 718.306, or if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Twenty C.F.R. § 718.202(a). Pneumoconiosis is defined in § 718.201 as a chronic dust disease arising out of coal mine employment. It is within the Administrative Law Judge's discretion to determine whether documentation adequately supports a physician's conclusions. *Lucostic v. United States Steel Corp*., 8 B.L.R. 1-46, 1-47 (1985). "An Administrative Law Judge may properly consider objective data offered as documentation and credit those opinions that are adequately supported by such data over those that are not." *See King v. Consolidation Coal Co*., 8 B.L.R. 1-262, 1-265 (1985).

A. X-ray Evidence

Under § 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (*en banc*); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP,* 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

There are a number of chest x-ray readings within the treatment records. None of the readings made a finding of pneumoconiosis. However, the readings also fail to provide the qualifications of the interpreters and the quality of the chest x-rays. Therefore, I give less weight to the chest x-rays located within the treatment records.

Dr. Wheeler, a Board-certified Radiologist and B-reader, interpreted the November 5, 2000, chest x-ray as negative for pneumoconiosis. However, Drs. Ahmed and Cappiello, both Board-certified Radiologists and B-readers, found the film positive. Accordingly, based on the preponderance of the positive readings by highly qualified physicians, I find the November 5, 2000, chest x-ray positive for pneumoconiosis. Next Dr. Ahmed interpreted the December 3, 2000, film as positive for pneumoconiosis. There are no other interpretations of this film within the record. Therefore, I find the film positive. Dr. Wheeler then interpreted the January 4, 2001, film as negative. Since there are no other interpretations of the film within the record, I find the film negative. Therefore, the radiological evidence relied upon by the parties includes two positive chest x-rays and one negative x-ray. I give these chest x-rays superior weight for they all comply with regulation requirements. Accordingly, pneumoconiosis has been established under § 781.202(a)(1) by a preponderance of the evidence.

B. Autopsy/Biopsy

Pursuant to § 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. Clinical pneumoconiosis consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis**, anthracosilicosis**, **anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silicotuberculosis,** arising out of coal mine employment. 20 C.F.R. § 718.202(a)(1).

The record includes an autopsy report conducted by Dr. LeVaughn on June 8, 2001, which was summarized above. (DX 12). In the autopsy report, Dr. LeVaughn opined that the Miner's death was the result of acute bronchopneumonia. He never diagnosed the Miner with pneumoconiosis. However, Dr. LeVaughn also submitted a supplemental report. In his new report he opined that the Miner suffered from pneumoconiosis. He based his opinion on his findings of "chronic ischemic changes with mild, focal, patchy interstitial fibrosis…mild to moderate centrilobular emphysema…containing small amounts of black pigment [and] focal subpleural black pigment." I find his opinion well-reasoned and well-documented. Accordingly, I find that Dr. LeVaughn's opinion supports a finding of pneumoconiosis under § 718.202(a)(2).

C. Presumptions

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in §§ 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, § 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

D. Medical Opinions

Section 718.202(a)(4) provides another way for a claimant to prove that he has pneumoconiosis. Under § 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion might support the presence of the disease if it is supported by adequate rationale, notwithstanding a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 9 B.L.R. 1-22, 1-24 (1986). The weight given to a medical opinion will be in proportion to its well-documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms, and patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Buffalo v. Director*, OWCP, 6 B.L.R. 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 B.L.R. 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (*en banc*).

The medical narrative reports are summarized above. Dr. Houser also opined that the Miner suffered from pneumoconiosis. (CX 5). He bases his opinion upon the Miner's history of exposure, chest x-ray data, and the pathology evidence. I find Dr. Houser's opinion well-reasoned and well-documented.

In contrast, Dr. Fino opined that the Miner's respiratory condition was related solely to smoking. (EX 4). Dr. Fino diagnosed the Miner with chronic bronchitis and emphysema based on the autopsy evidence. However, he stated that based on the microscopic description of the lungs, the conditions were unrelated to coal dust exposure. He found that there was insufficient evidence to make a diagnosis of pneumoconiosis. Dr. Fino's opinion is well-reasoned and well-documented.

Dr. Jarboe also opined that the Miner did not suffer from pneumoconiosis. (EX 1). He based his opinion on the chest x-ray and autopsy evidence. He placed great weight on the fact that Dr. LeVaughn did not diagnosis pneumoconiosis in the autopsy report. However, Dr. Jarboe also based his opinion upon the lack coal dust macules in the Miner's lungs. He further stated that there was no evidence of a restrictive disease. Dr. Jarboe's opinion is well-reasoned and well-documented.

Therefore, the record includes two well-reasoned and well-documented medical narrative reports finding no pneumoconiosis and one finding pneumoconiosis. Also the record includes a

report from Dr. LeVaughn who performed the autopsy and opined that the Miner suffered from pneumoconiosis. I place great weight upon Dr. LeVaughn's opinion. It is reasonable to assign greater weight to the opinion of the physician who performs the autopsy over the opinions of others who review only his or her findings without reviewing the slides. *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985); *Fetterman v. Director, OWCP*, 7 B.L.R. 1-688 (1995). None of the other physicians of record reviewed the autopsy slides. Furthermore, I found that the chest x-ray data supports a finding of pneumoconiosis. Therefore, I find that the positive evidence outweighs the negative. Accordingly, I find that Claimant has established pneumoconiosis under § 718.202(a)(4).

Causation of Pneumoconiosis

Once it is determined that a miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). The burden is upon Claimant to demonstrate by a preponderance of the evidence that the Miner's pneumoconiosis arose out of his coal mine employment. 20 C.F.R. § 718.203(b) provides:

> If a miner who is suffering or has suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arouse out of such employment.

Id.

The Miner was employed for 10 years in coal mine employment. Therefore, Claimant is entitled to the rebuttable presumption that the Miner's pneumoconiosis arose out of such employment. Since there is no evidence in the record to rebut this presumption, I find Claimant has proven that the Miner's pneumoconiosis arose out of his employment in the coal mines under 20 C.F.R. § 718.203(b).

Death Due to Pneumoconiosis

Assuming that pneumoconiosis was established, a claimant must also prove that the miner's death was caused by pneumoconiosis. Under § 718.205(c), a miner's death is considered to be due to pneumoconiosis in any of the following circumstances: (1) where competent medical evidence establishes that the miner's death was due to pneumoconiosis; (2) where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis; or, (3) where the presumption set forth at § 718.304 is applicable. Survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition unrelated to pneumoconiosis. 20 C.F.R. § 718.205(c)(4). The presumption at § 718.304 does not apply to this claim.

Like several other federal circuits, the United States Court of Appeals for the Sixth Circuit has interpreted "substantially contributing cause" to include a hastening of the miner's death. *Griffith v. Director, OWCP*, 49 F.3d 184, 186 (6th Cir. 1995). *See Northern Coal Co. v.*

Director, OWCP, 100 F.3d 871, 874 (10th Cir. 1996); *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178, 183 (7th Cir. 1992); *Shuff v. Cedar Coal Co*., 967 F.2d 977, 980 (4th Cir. 1992); Lukosevicz v. Director, OWCP, 888 F.2d 1001 (3d Cir. 1989). This interpretation means that any acceleration of the miner's death that is attributable to pneumoconiosis will entitle Claimant to benefits. *See Griffith*, 49 F.3d at 186.

In order to establish that the miner's death was due to or hastened by pneumoconiosis, a physician's opinion must be adequately documented and reasoned. *See Addison v. Director, OWCP*, 1-68, 1-69 (1988). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984). A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*.

Drs. Jarboe and Fino both opined that the Miner did not suffer from pneumoconiosis. It is proper for an Administrative Law Judge to accord less weight to a physician's opinion that is based on premises contrary to the Judge's findings. *See Scott v. Mason Coal Co.*, 289 F.3d 263 (4th Cir. 2002); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995); *Grigg v. Director, OWCP*, 28 F.3d 416 (4th Cir. 1994); *Amax Coal Co. v. Director, OWCP [Chubb]*, 312 F.3d 882 (7th Cir. 2002). Accordingly, I give less weight to the opinions of Drs. Jarboe and Fino on the issue of death due to pneumoconiosis. Furthermore, Dr. Fino's supplemental opinion only discusses total disability and not the Miner's death. Therefore, I would have discounted his opinion even if he had found pneumoconiosis.

The Death Certificate identified the Miner's cause of death as chronic lung disease. (DX 10). A death certificate, in and of itself, is an unreliable report of the miner's condition and it is error for an Administrative Law Judge to accept conclusions contained in such a certificate where the record provides no identification that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. *Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988). The Board has also held that a physician's opinion expressed on a death certificate in addition to his testimony is sufficient to establish the cause of the miner's death. *Dillon v. Peabody Coal Co.*, 11 B.L.R. 1-113 (1988). Dr. Hardison, the Miner's treating physician, signed the Death Certificate. (DX 10). Although Dr. Hardison obviously had personal knowledge of the Miner's condition, he never attributed the Miner's chronic lung disease to coal dust exposure. Even Dr. Hardison's treatment records fail to relate the condition to coal dust exposure. Therefore, I find his opinion unreasoned and undocumented.

Dr. LeVaughn performed the autopsy report and opined that the Miner died as a result of acute bronchopneumonia. (DX 12). Although in his supplemental report he opined that the Miner suffered from pneumoconiosis, he never discussed the Miner's cause of death. (CX 4). Accordingly, I give Dr. LeVaughn's opinion on the issue of death due to pneumoconiosis less weight.

In contrast, Dr. Houser opined that the Miner's pneumoconiosis contributed to his death. (CX 5). Dr. Houser relied upon his extensive medical research and the Miner's history of respiratory failure. He related the Miner's conditions to coal dust exposure. Dr. Houser's opinion is well-reasoned and well-documented on the issue of pneumoconiosis.

Accordingly, I find that Claimant has established by a preponderance of the evidence that the Miner's death was hastened by pneumoconiosis.

ENTITLEMENT

In sum, Claimant has established by a preponderance of the evidence that the Miner suffered from pneumoconiosis and that his death was hastened by his coal dust exposure. Therefore, Claimant's claim for benefits under the Act shall be granted.

Attorney's Fees

No award of attorney's fees for service to Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for Claimant's counsel to submit an application. *Bankes v. Director*, 8 B.L.R. 2-1 (1985). The application must conform to 20 C.F.R. §§ 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a Service Sheet showing that service has been made upon all parties, including Claimant and Solicitor, as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge Claimant any fee in the absence of the approval of such application.

ORDER

It is HEREBY ORDERED that:

1. The claim for benefits of C.H. under the Act is hereby GRANTED;

2. The Employer shall pay C.H. all benefits to which she is entitled under the Act, beginning June 2001; and,

3. The Employer shall pay Claimant's attorney fees and expenses to be established in a supplemental decision and order.

A

JOSEPH E. KANE
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the Administrative Law Judge's Decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the Administrative Law Judge's Decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* C.F.R § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's Decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).